Care Quality Commission

Review of compliance

Magicare Ltd
Priscilla Wakefield House

Region:	London
Location address:	Rangemoor Road, Tottenham, London N15
Type of service:	Care home with nursing
Date the review was completed:	29 10 2010
Overview of the service:	Priscilla Wakefield House is registered to accommodate 112 people. The home provides accommodation and care to people living in separate units within the home. People living at this home are older people who have nursing or care needs and who may have dementia, and younger adults who have dementia or who have an acquired brain injury and physical disability. The home is located in Tottenham, close to public transport and local shops.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Priscilla Wakefield House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 October 2010, observed how people were being cared for, talked to people who use services, talked to staff and the manager, checked the provider's records, and looked at records of people who use services. We also talked to people responsible for overseeing the care provided to individual people in the home (representatives from Primary Care Trust and social services) and two relatives.

What people told us

We talked to people living in the home and spent at least one hour in each unit observing the care and lifestyle that people experience. We also spoke with some people outside the home who visit regularly. Overall the feedback was that people are provided with a good standard of care, seem to be settled in the home, are given choices and have the opportunity to form good relationships with staff. Staff ask them what their needs and wishes are. People said they would like more to do as their activity needs were not being met at the time of this review.

What we found about the standards we reviewed and how well Priscilla Wakefield House was meeting them.

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People living in this home are encouraged to express their views on the care provided to them and make decisions about their care.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There was good practice in the home as staff listen to people's views, encourage relatives and advocates to speak for people who cannot speak for themselves and a best interest meeting was being set up to help a resident who disagreed with his care plan. However the provider (Magicare Ltd) will need to ensure that residents of the home are assessed for their ability to give informed consent to care and treatment (mental capacity assessments).

- Overall, we found that Priscilla Wakefield House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights.

The home is providing a satisfactory standard of care and staff work hard to meet people's individual needs. Improvements are needed in providing activities for people living at the home as well as ensuring their risk assessments are completed and up to date so that they can be sure they will experience safe and appropriate care.

- Overall, we found that improvements are needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

The home provides residents with a choice of nutritious food and drinks and the support they need to enjoy a good healthy diet.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

Staff support people living at the home to obtain the health and specialist support they need. Professionals involved with residents of the home say that this home cooperates with them in providing the care people need.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 7: People should be protected from abuse and staff should respect their human rights

Magicare Ltd is training staff to protect people from abuse. All staff need to have this training to help them respond properly to any allegation of abuse. They need to make sure any unexplained injury is investigated in order to ensure people are kept safe.

- Overall, we found that improvements are needed for this essential standard.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

Residents of the home are protected by a good standard of hygiene and cleanliness.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

Medicines management in the home is generally satisfactory, but some improvements are needed to protect people against risks of unsafe management of medicines.

- Overall, we found that improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People live in an environment which appears to be safe and well maintained.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

The equipment that residents use is properly maintained to ensure it is safe and suitable for use.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

Magicare Ltd has a system in place to check the suitability of staff before they are employed in the home.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

At the time of this visit there were sufficient numbers of qualified and experienced staff working to meet the residents' needs.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff providing the care at this home are provided with training and supervision to help them provide good care.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Six months ago, we considered that this home provided a poor quality service to residents. We saw at this visit that there have been many improvements, that Magicare Ltd have listened to the views of others and have continued to improve to provide a better service for residents.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

The home has a complaints system in place so that people can expect any complaint to be recorded and responded to properly.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The home's record keeping was generally of a good standard which helps to protect people against the risk of unsafe or inappropriate care.

- Overall, we found that Priscilla Wakefield House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found

for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We visited all the units within the home. We also looked at the care plans for eleven of the fortynine people living in the home. The care plans described what people's needs and wishes are. In two of the eleven care plans seen, the person had written the care plan for themselves. One person said that he had told staff what his needs were and was satisfied that they were meeting his needs.

Other evidence
A relative of one person, who had communication difficulties, told us that s/he had been asked to speak for the person and had written down their likes and dislikes and what support they needed to help staff look after this person properly.

In April 2010 we told Magicare Ltd that they must provide information to people who use Priscilla Wakefield House for respite care (this is temporary care) so that they know what they can expect. We saw that this had been provided to the one person who was staying at the home for respite care. This person told us s/he was there

whilst the people who usually support him/her were on holiday. S/he said that staff at the home allow him/her to make decisions about his/her care and respect his/her wishes.
The home has recently introduced a new care plan format which asks people what their needs are. This is positive. The manager sent us results of a recent survey the home did with residents. This showed that the home does try and seek people's views on the care provided. The results of the survey showed that generally people were satisfied with the care provided.

Our judgement
People living in this home are encouraged to express their views on the care provided to them and make decisions about their care.

Outcome 2:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

The provider is compliant with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us
One person told us s/he was not allowed out and was not happy about that. We saw that this person's care plan said s/he was not allowed to go out alone. The reasons for this were recorded properly and the decision had been made by professionals responsible for the person's care. Magicare Ltd showed us that they were applying for a 'Deprivation of Liberty Safeguard' for this person. This is good practice and means that an independent person will check whether this decision is in the best interests of the person concerned and a date will be planned for when this decision will be reviewed to see if it is still necessary

Other evidence
We noted in our inspection of eleven people's care files that there were no mental capacity assessments in place for some people. This assessment is needed so that staff know if the person is able to give consent to their treatment or not. We did see evidence in two care plans and by talking to a relative that the home has asked the opinion of the person who knows the resident best when planning their care.
We did not find any instances of poor practice where the home had acted without a person's consent. We observed staff working with residents in each unit in the

home and saw them treat people with respect We were informed that one of the residents whose care we looked at, had an advocate who visits regularly as this person lacks the capacity to speak for himself.

Our judgement

There was good practice in the home as staff listen to people's views, encourage relatives and advocates to speak for people who cannot speak for themselves and a best interest meeting was being set up to help a resident who disagreed with his care plan. However the provider (Magicare Ltd) will need to ensure that residents of the home are assessed for their ability to give informed consent to care and treatment (mental capacity assessments).

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We observed six people in one unit for one hour to see if they were offered anything to do other than watch television. We observed that staff did tell one person that a programme she liked was on and switched channels for her to watch it. We saw that one person had a visitor and another went out of the unit with staff for a cigarette. There were no other activities offered to anyone. We also spoke with three people on the unit to ask them how they liked to spend their time. Two said they would like some activities. One said "It's a bit dead here," and the other said , "I would like something to do. There's not much to do." The third person was not sure what she wanted to do with her time. We also spent time on all the other units in the home. We observed that staff, where they had time, were trying to occupy and stimulate people but that they were also busy meeting care and nursing needs. We saw a nurse reading a newspaper to a resident.

Other evidence
Many people in this home have communication difficulties due to dementia or another kind of cognitive impairment. This means they have difficulty in remembering things and expressing themselves. As we knew some people could not talk to us, we looked at how they are looked after in a different way, called pathway tracking. We looked at the written assessment of their needs and

preferences, their care plan which should state what their needs are and other records such as a risk assessment. The risk assessment describes what risks there are to that person's safety (for example, falling over, harming themselves, etc) and what staff should do to help them. We also spent time in the units observing that person and in some cases we spoke with a relative or social worker or other professional to ask them whether the home was meeting their needs. We looked at care plans belonging to eleven people. We saw that Priscilla Wakefield House had assessed their care and nursing needs and there was a written assessment in each person's file. Each person had a care plan which described their care and nursing needs. Care plans showed that the person had been asked about their needs and likes/dislikes where they were able to speak for themselves. The care plans had a list of questions for staff to ask but there were no questions about hobbies or how they like to spend their time. Some plans were not signed by the person concerned and there was no evidence that they had been involved in writing them. The care plans are new and this may be why this had not yet been completed. The manager said the care plans will be reviewed every month to make sure that they are updated if a person's needs change in any way.

Our judgement
Improvements are needed to comply with this essential standard. The home is providing a satisfactory standard of care and staff work hard to meet people's individual needs. Improvements are needed in providing activities for people living at the home and ensuring their risk assessments are completed and up to date so that they can be sure they will experience safe and appropriate care.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We asked twelve people for their opinion on the food in the home. Four were not able to remember the meals they had eaten. Five said the food was "alright" but could not think of any improvements they would like. Three said the food was good. As many of the people living at the home have short term memory loss, we decided to observe mealtime as well as ask people's views on the food. We observed lunchtime on four units. We saw that staff supported people to choose their meal and to make the mealtime a pleasant experience. One person said that staff ask him every morning before 11am to choose his lunch. We noted that even though people had made their choices before 11am , at the meal table they were offered a choice again as they may have forgotten what they chose earlier. We also saw that people could have their own choice. For example, one person chose fish and had it with both chips and mashed potato. There was a choice of vegetables and salad and we saw that some people chose both. We saw that the chef had prepared attractive meals for people who needed their food pureed. The fish, potato and vegetables were pureed separately and staff explained what each item was. The menu on the day of our visit was a choice of two hot meals. There was cod or cauliflower and broccoli cheese with a choice of mashed potato or chips and salad or peas. Menus were available on the tables in the dining room in every unit. The menu also listed alternative and special meals that people could ask for. There was a good selection of salads, jacket potato fillings, soup, sandwiches, vegetable chow mein, chicken curry and Jerk chicken on the menu. We asked for one of these

special meals and found it was easily available. There was a choice of desserts too. People could choose to sit alone or with others depending on their preferences.

Other evidence
We saw jugs of drinks and bowls of fruit on the tables in each unit so that people could help themselves during the day. We checked the food and fluid charts for one person whose weight was being closely monitored. We saw that all food and drinks were being recorded properly so that staff knew what this person had eaten each day. We saw that a nutritional assessment was used to help staff know how often they should check a person's weight and whether they need any support with eating. We saw that one person was fed through a tube and that good records were being kept to make sure this person received enough nutrition.

Our judgement
The home provides residents with a choice of nutritious food and drinks and the support they need to enjoy a good healthy diet.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
We saw one resident who lived in the residential unit (which does not provide nursing care) with wounds that clearly needed attending to. We looked at this person's care records and saw that staff had contacted the Tissue Viability Nurse (a nurse who specialises in care of wounds and prevention and treatment of pressure sores). The district nurses had been asked to come and attend to the person's wounds and had not done so. The Clinical Nurse Specialist in the home told us she was going to contact the Community Matron to resolve this issue. Despite the risk to the resident of not receiving the care she needed, we saw evidence that the home was actively contacting other providers to help with this matter. This was an example of good practice. We also saw that staff ensured this person received the medical attention she needed while we were in the home. We also saw that the home worked with Speech and Language therapists where they were needed to help residents.
We checked health records for seven people and found that staff had supported them to attend medical appointments.

Other evidence
We spoke with two social workers and a nurse who were responsible for reviewing the care of a total of fourteen people who currently live at this home. All three said that the provider and staff at the home cooperated with them and communicated

with them about the residents. One said that one woman living at the home had found it difficult to settle in and had experienced some health problems but that the home had supported her well and regularly kept the social worker informed about how she was. Another social worker said she was "always happy" with the way the home cared for a particular man there. A relative said she was regularly informed if there were any concerns and accidents. The manager told us that he is meeting with the home's GP and that this would happen on a regular basis to discuss any concerns. This is positive. A representative from the Primary Care Trust told us he had developed a good relationship with staff at the home.

Our judgement

Staff support people living at the home to obtain the health and specialist support they need. Professionals involved with residents of the home say that this home cooperates with them in providing the care people need.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We didn't ask any residents on this visit if they knew what to do if they were being abused.

Other evidence
At the time of this review, there were two safeguarding concerns which we discussed with the manager. These were incidents where a resident of the home may have experienced abuse and the home reported this to Haringey Council to be investigated.

We looked at the training records to see how many staff had been trained in safeguarding procedures. This training tells staff about different types of abuse and what they must do if they think a resident may have been abused. 80% of staff had completed an online (computer based) training on safeguarding. The manager told us that this training has a test at the end to check if staff had understood it and that the manager checks whether staff have passed the test. Twenty six staff had attended a training session on safeguarding. When staff are trained they are more likely to spot signs of abuse and act properly to protect people. The manager said another training session would be held for the other staff.

We noted from one resident's care records that s/he had an unexplained bruise and although a record had been made of this, there was no record of any investigation of the cause and no record that the next of kin or social worker had been informed. There was evidence of incidents where the home had acted promptly to protect people and keep them safe.

We checked the financial records for two people to see if all their money could be accounted for and whether proper records were being kept of money they spent. There were no concerns found about the home's management of these two residents' money.

The provider has not complied with a requirement made by us in April 2010 to open individual bank accounts for those people who had nobody to help manage their finances. However they have made improvements in the way they manage people's money. Individual balance sheets are kept for people whose money is managed by Magicare Ltd. Due to the improvements made we are taking no further action.

Our judgement
Magicare Ltd is training staff to protect people from abuse. All staff need to have this training to help them respond properly to any allegation of abuse. They need to make sure any unexplained injury is investigated in order to ensure people are kept safe.

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

The provider is compliant with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not ask any residents about cleanliness. We did observe care staff and nurses using gloves and washing their hands.

Other evidence
We inspected all the lounges, corridors and dining rooms in the home plus a small sample of bedrooms and bathrooms. There were no concerns about cleanliness or infection control. The home was very clean. There was antibacterial handwash outside every unit. One of these dispensers was empty but staff refilled it as soon as we pointed this out.
The laundry chute where staff can put bags of soiled linen was broken on the day of our visit. There were signs telling staff not to use it. Staff were taking bags of laundry in the lift which was acceptable. The laundry room was clean and there were suitable washing machines with sluice facilities to clean soiled linen and clothes.

Our judgement
Residents of the home are protected by a good standard of hygiene and cleanliness.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
Our pharmacist inspector observed medication in the home and made the below report.

Other evidence
At the last key inspection in April 2010, we issued 2 statutory requirement notices on medicines handling, as there were a number of serious issues with the way the service was managing medicines which could have put people at risk. We visited again in June 2010. We found that medicines management had improved, and the 2 statutory notices had been complied with. We left a requirement for the service to continue auditing medicines handling to provide an assurance that medicines were being used safely and as prescribed.

At this visit, we found evidence that some of the improvements have been maintained. All prescribed medicines were available at the home on the day of the visit. There were no gaps in recording when medicines are given to people so it was clear when people received their medicines. Medicines are being stored safely, and at the correct temperatures. One person is taking a prescribed controlled drug. This is being stored according to legal requirements, and records of use are accurate. Records are kept of medicines received from the supplying pharmacy, medicines

used, and medicines returned to the clinical waste company, therefore medicines kept on behalf of people at the home can be accounted for. One person is keeping and taking their own medicines to maintain their independence. Lockable storage is supplied in their rooms to store their medicines, and a risk assessment is in place to confirm that they are able to take their medicines safely. People we spoke with said they have been given information on what their medicines were for. Arrangements are being made to obtain patient information leaflets for all medicines kept at the home. Regular audits are being carried out by the Clinical Development Nurse and there is evidence that action has been taken on the issues found during these audits. At the start of the month, two prescribed medicines for one person had not been received on time, so this person had missed a single dose of each. There was evidence that staff at the home had ordered these medicines on time and had also contacted the GP several times to report that the medicines had not been received. The homes Manager is also having regular meetings with the GP to ensure medicines are received on time.

Areas for improvement.

We saw staff giving medicines to people on 3 units during lunch. Medicines were sometimes left out on dining tables while people finished their meals. On one unit, staff signed the administration record after checking that medicines had been taken, however on another unit, staff signed the administration records before checking the medicines had been taken. Leaving medicines out without making sure they have been taken could put people at risk. This has a high impact on people who use the service, as if medicines are left out, medicines could be taken by the wrong person or not at all.

Some people are on medicines to be given as needed e.g. painkillers and sleeping tablets. There should be clear guidance on when these should be used, especially for people who may not be able to communicate verbally when they are in pain. This has a high impact on people who use the service, as people who are in pain may not get pain relief when it is needed.

Staff now record when topical medicines such as creams are used, and also when food supplements are given. It would be good practice to record the area of application for each cream on the administration record, especially as some people with dementia have been prescribed several creams, for application to different areas, and it isn't clear from the records where the creams should be applied. The quantities of food supplements in stock for each person should also be recorded, as without this, it will not be possible to confirm that these people are receiving these as prescribed.

Two people are refusing to take some essential medicines. Staff have obtained written confirmation from their next of kin and the prescriber that these medicines can be crushed and added to food. This is covert administration. We did not see evidence of a best interests meeting, or an assessment under the Mental Capacity act. Confirmation should also be obtained from the supplying pharmacist that crushing these medicines won't affect the properties. The need to do this is stated in the homes medicines policy. There should be a care plan to ensure that these medicines are used safely e.g. what the medicine should be added to, who is responsible for checking the food has been taken, and what to do if the food

containing medicines is refused.

Some improvements are needed for medicines with a variable dosage e.g. one person is on lactulose, five to ten mls to be given when needed. Staff do not always state exactly how much is given at each dose.

Over the counter medicines are kept for minor ailments, these are known as "Homely Remedies". A log is kept of the medicines kept and the quantities held. These were not always accurate e.g. there was twice as much lactulose in stock as recorded in the log book, it was difficult to locate the bottle of simple linctus as it was not being stored with the other Homely Remedies, and there was no Gaviscon Liquid in stock.

There were several crates of medicines awaiting disposal. Some had not been collected since June 2010. These are stored separately to medicines currently in use, and don't pose any risk to people at the home. An oxygen cylinder no longer in use was being kept in an empty bedroom. Unwanted medicines should be disposed of promptly.

Our judgement

Some improvements are needed to protect people against risks of unsafe management of medicines.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The home is divided into separate units each with their own lounge, kitchen, dining room and toilet and bathroom. People live in units with others who have a similar disability to them. People who have challenging behaviour live separately to those who are frail. We asked two people for their views on the home and whether they felt safe there. Both said the home was comfortable and that they felt safe.

Other evidence
We checked a sample of records to see if the building was safe and well maintained. We saw that the home passed the most recent gas and electrical safety inspections. The home employs a handyman to keep the building well maintained.
We saw that the home has a fire risk assessment and that fire drills are taking place regularly. This is an improvement since our last visit in April 2010. We looked at the records of staff induction training. This is the training that the home gives staff when they start working there. We noted that there was no record that staff are told on the first day of work what to do if there is a fire. The manager said that the fire procedure is explained to staff. We told the manager that this should be recorded as evidence that staff are told this as soon as they start work . We did see records showing staff had attended training in fire safety. We tested four fire doors to see if they closed properly, which they did.

Our judgement
People live in an environment which appears to be safe and well maintained.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We observed people using wheelchairs and zimmer frames which all appeared to be in good condition.

Other evidence
We checked records in the home to check safety of equipment. We saw that the home's four hoists which are used to move people who cannot walk had been checked for safety. The lift had been serviced in May and August 2010 and portable electrical appliances had been checked and found safe in September 2010.

Our judgement
The equipment that residents use is properly maintained to ensure it is safe and suitable for use.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We observed that staff knew people well and were patient and supportive.

Other evidence
We checked the recruitment process for one of the five staff that have been employed since our last visit in April 2010. We saw that Magicare Ltd had checked this person's suitability to work in the home. We also saw that there was a qualified nurse on duty in each of the nursing units. We looked at files for two new staff and saw that they were provided with induction training so that they know what is expected of them in their role.

Our judgement
Magicare Ltd has an effective system in place to check the suitability of staff before they are employed in the home.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spent time in each unit observing how staff were spending their time with the residents. We saw that staff were busy but they had good knowledge of people's needs and had formed good relationships with them. We asked five residents for their views on the staff. All said that they liked the staff and felt they treated them well.

Other evidence
We looked at staff rotas for a period of three weeks to see if there were enough staff on duty to care for the residents. We also talked to the manager about staffing levels. We spoke to twelve staff. Staff said they work mainly on one unit so they get to know the residents well. Rotas showed that most staff work long shifts which means residents get to spend all day with the same people.

We considered everybody's views and thought that for the number of people living in the home on the day of our visit (49) and their needs, there appeared to be enough staff to meet their needs. We advised one of the Magicare Ltd directors that staffing levels need to be reviewed regularly and when new people move in. The manager said he reviews staffing needs every month when he receives a report from each unit. We did not look at written evidence of this. We also checked that there was a suitably qualified nurse in each unit. There were five new staff but the majority of

staff had worked at the home for some time and were experienced.

Our judgement
At the time of this visit there were sufficient numbers of qualified and experienced staff working to meet the residents' needs.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We did not ask residents about staff training and supervision

Other evidence
Supervision of staff has improved in the last six months. In April 2010 we told Magicare Ltd that staff supervision must improve by July. The improvements have now been made. Staff told us they were having individual supervison sessions to discuss their work. We asked two staff responsible for supervising other staff if they had been provided with training on how to do this. Both said they had. We saw that the manager was keeping a record of when supervision was taking place. We also saw that the manager took action when staff did not meet expectations, which was good evidence that staff were being supervised to ensure they are doing their job properly.
We asked six staff about the training they had been provided with. We also looked at records of staff training. There was a good staff training programme. Staff said they had received a lot of training in recent months. Some examples of this were; end of life care, safeguarding people and working with people with dementia. They said this helped them to work with the residents and understand their needs. One nurse said that end of life training helped her ensure that good nursing care was provided to residents who were near the end of life.
Staff told us they felt supported and made positive comments about the new manager and the training they had been provided with.

Our judgement
Staff providing the care at this home are provided with training and supervision to help them provide good care.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not discuss this with residents at the home.

Other evidence
The manager gave us a copy of the last quality assurance exercise where people were asked for their views on the care provided at this home. This showed that people were generally satisfied with the home. We spoke to three professionals who all said they were satisfied that the home was providing good care.

Magicare Ltd paid two independent consultants to inspect the home and report on their findings. We saw these reports and saw that Magicare Ltd had acted on recommendations made. This was evidence that Magicare Ltd have made improvements in the home in the last six months and continue to make improvements and listen to the views of other professionals.

Our judgement
Six months ago, we considered that this home provided a poor quality service to residents. We saw at this visit that there have been many improvements, that Magicare Ltd have listened to the views of others and have continued to improve to provide a better service for residents.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We did not discuss complaints with residents at this visit.

Other evidence
We checked the records of the complaints about the home. We saw that two people had made a complaint to the home recently. The manager had written to the complainants and acted to try and sort out the problems. A GP had complained about the home. The manager said he was now meeting with the GP regularly to discuss any problems.

Our judgement
The home has a complaints system in place so that people can expect any complaint to be recorded and responded to properly.

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not discuss records with residents.

Other evidence
We looked at care records for eleven of the fortynine residents. A lack of up to date risk assessments for some residents has been addressed under outcome 4. Other care records and staff records that we inspected were up to date.
The assessment and care plan by the placing authority (people who arranged the person's stay at this home, which is usually a Council or Primary Care Trust) were not always available in care records. This means we could not check if the home's own assessment and care plans contained important information about the person before they moved into the home. We are asking them to keep these records.
Despite this, the views of the people responsible for the placement of fourteen people at the home were that their needs were being met and that there were no major concerns. All the staffing and health and safety records that we saw were in good order. This means the home's record keeping was generally of a good standard.

Our judgement
The home's record keeping was generally of a good standard which helps to protect people against the risk of unsafe or inappropriate care.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>18</td><td>2 Consent to Care and Treatment</td></tr>
<tr><td colspan="2">Why we have concerns:
There was good practice in the home as staff listen to people's views, encourage relatives and advocates to speak for people who cannot speak for themselves and a best interest meeting was being set up to help a resident who disagreed with his care plan. However the provider (Magicare Ltd) will need to ensure that residents of the home are assessed for their ability to give informed consent to care and treatment (mental capacity assessments).</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>18</td><td>2</td></tr>
<tr><td colspan="2">Why we have concerns:
Care plans showed that people had been asked about their needs and preferences but some had not yet been signed by the person, or by somebody on their behalf, to show that they have seen the care plan and agree to it.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>11</td><td>7 Safeguarding people who use services from abuse</td></tr>
<tr><td colspan="2">Why we have concerns:
Magicare Ltd is training staff to protect people from abuse. All staff need to have this training to help them respond properly to any allegation of abuse.</td></tr>
</table>

Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures	13	9 Management of medicines
	Why we have concerns: Guidance on when to give people medicines that are given as and when needed was not specific enough. This is needed to ensure people get their medicines when they need it.	
Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures	13	9 Management of medicines
	Why we have concerns: Care plans for people who receive their medicines without their knowledge need more detail (as described under outcome 9 in our findings) to ensure that medicines are being given safely.	
Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures	13	9 Management of medicines
	Why we have concerns: There were several crates of medicines awaiting disposal. Some had not been collected since June 2010. These are stored separately to medicines currently in use, and don't pose any risk to people at the home. An oxygen cylinder no longer in use was being kept in an empty bedroom. Unwanted medicines should be disposed of promptly.	
Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures	15	10 Safety and suitability of premises
	Why we have concerns: We noted that there was no record that staff are told on the first day of work what to do if there is a fire. The manager said that the fire procedure is explained to staff. We told the manager that this should be recorded as evidence that staff are told this as soon as they start work . We did see records showing staff had attended training in fire safety.	
Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures	20	21 Records
	Why we have concerns: The assessment and care plan by the placing authority (people who arranged the person's stay at this home, which is usually a Council or Primary Care Trust) were not always available in care records. This means we could not check if the home's own assessment and care plans contained important information about the person before they moved in.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>9</td><td>4 Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Improvements are needed in providing activities for people living at the home to meet their social and recreational needs.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>9</td><td>4 Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People's risk assessments are not all completed and up to date. This needs to be done so that they can be sure they will experience safe and appropriate care.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>11</td><td>7 Safeguarding people who use services from abuse</td></tr>
<tr><td colspan="2">How the regulation is not being met:
There was one unexplained bruise that had not been investigated or reported. Magicare Ltd need to make sure any unexplained injury is investigated in order to ensure people are kept safe.</td></tr>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury, diagnostic or screening procedures</td><td>13</td><td>9 Management of medicines</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Leaving medicines out without making sure they have been taken could put people at risk as they could be taken by the wrong person or not at all.</td></tr>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA